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STATE HEALTH NOTES

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States, Feds Tackle Obesity, Soon to Kill More People than Tobacco

When it comes to losing weight, the options seem endless. High carbs, low fat? Low carbs, high protein? The South Beach Diet®, Weight Watchers®, Atkins ®? Each year, consumers spend up to $100 billion on diet-related products, but Americans keep getting fatter.

Almost 130 million Americans are overweight or obese, and those numbers are climbing. The proportion of Americans who are overweight (10 to 15 pounds too heavy) or obese (roughly, 30 pounds overweight) rose from 60 percent of the general population in 1990 (20 percent of whom were obese), to 64 percent in 2000 (30 percent obese).

Approximately 50 percent of deaths that occurred in 2000 were generally preventable, according to a study in the March 8 *Journal of the American Medical Association*. Of those preventable deaths, an estimated 400,000 people, or 16.6 percent, died from causes related to poor eating habits and sedentary lifestyles, up from 300,000 deaths, or 14 percent, in 1990.

The rates of overweight and obesity have increased among both men and women in all age ranges, ethnic groups and educational levels. Obesity among children also is on the rise. According to the 1999-2000 National Health and Nutrition Examination Survey (NHANES), 9 million (about 15 percent) of youngsters aged 6-19 years are overweight, triple the proportion in 1980.

Perhaps most alarming is that the rates of obesity are expected to climb. Researchers from the Centers for Disease Control and Prevention (CDC) point out that physical inactivity and poor diet are increasing, with the result that mortality rates will rise. The crisis has reached such proportions that obesity is rapidly overtaking smoking as the leading cause of preventable death, the CDC says. By next year, obesity is expected to cause more than 500,000 deaths annually -- it will kill more Americans than all forms of cancer.

This is disturbing news for public health officials, Congress and state legislatures, in part because the costs associated with bulging waistlines are starting to break the bank. In 2003, the total direct and indirect costs of overweight and obesity, including medical care and lost productivity, topped $117 billion, with taxpayers footing half the bill through Medicare and Medicaid. In January, *Obesity Research* published a study showing that medical expenditures caused by obesity range from $87 million in Wyoming, including $15 million in Medicare expenditures and $23 million in Medicaid, to $7.7 billion in California, with $1.7 billion in Medicare and Medicaid spending each.

"We're literally eating ourselves to death," said Indiana Rep. Charlie Brown. "States are going to have to get a lot more aggressive with their policies if we're ever going to get on top of this epidemic."

NEW FOOD GUIDELINES

Recognizing the hefty toll that overweight and obesity have on health outcomes and the bottom line, the Food and Drug Administration (FDA) weighed in on March 12 with a report called "Calories Count." Put together by the FDA's Obesity Working Group, the report outlines a number of strategies to help tackle the obesity epidemic.

The Calories Count proposals are based on the theory that weight control is mainly a function of caloric balance: that is, calories in must equal calories out. As such, the "Calories Count" recommendations include: modifying the nutritional information chart on food packages to display calorie count more prominently; using more meaningful serving sizes (for example, foods that people consume in one sitting should be labeled as one serving); encouraging restaurants to provide nutritional information; stepping up enforcement actions on the accuracy of food labels; defining

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what foods can be labeled "low" or "free" of carbohydrates; encouraging food manufacturers to use dietary guidance statements; and, strengthening the obesity research agenda at the CDC, the FDA and the National Institutes of Health.

Critics, however, argue that the recommendations don't go far enough. Food labels are "one small piece of the [obesity] equation," said Margo Wootan, director of nutrition policy at the Center for Science in the Public Interest. To effectively deal with obesity, a number of other issues must be addressed, including school nutrition, and nutrition education and food marketing policies, particularly those aimed at children. Food labeling will do "almost nothing" to stem the rise of obesity unless other aspects of "our toxic food environment" receive attention, she argued.

Whether food manufacturers and chain restaurants will actually comply with the FDA recommendations remains to be seen; Wootan thinks not. "They've always had the opportunity to label food voluntarily but to date have chosen not to," she said. "Expecting them to police themselves now is naïve."

Wootan also is critical of the emphasis on personal responsibility in managing weight. "When only one-third of fast food chains have nutritional information readily available, in an easy-to-understand format, it's almost impossible for citizens to make wise food choices," said Wootan. Focusing on personal responsibility "abdicates the share of responsibility of others, including government [and] food manufacturers," she said. "We all own a piece of this problem."

STATE ACTIVITY

The rising rates and costs of obesity have spurred state legislators into action. In 2003-2004, state legislatures considered 330 bills, many of them aimed at children, with others targeting adults. The bills would improve nutrition standards in schools, implement nutrition and physical education policies, and increase opportunities for citizens to be physically active in their communities.

States are implementing campaigns to increase the public's awareness of the dangers of obesity; mandating insurance coverage for obesity reduction treatments and prevention programs; requiring nutrition education and nutritional standards in schools; imposing taxes on certain foods or beverages with limited nutritional value; supporting safe walking or biking routes to schools; and, creating task forces to make recommendations for the prevention of obesity. Below are descriptions of how two states are seeking to trim the collective waistline.

HEALTHY HAWAII

In Hawaii, the rate of childhood obesity is twice the rate on the mainland, and almost half of state residents don't engage in sufficient physical activity. But state legislators are determined to reverse that.

Last year, Rep. Dennis Arakaki introduced several bills to encourage the development of healthy eating and exercise habits among school-aged children. Among other things, the bills would increase reimbursement for school meals meeting the United States Department of Agriculture (USDA) nutrition standards; encourage the sale of full school meals, rather than *a la carte* options (chain restaurant selections); restrict the sale of snack items during meal times; and allow only water, milk, or 100 percent fruit juice to be sold all day at elementary schools.

Despite the general recognition by the legislature that obesity is a serious problem, "there is little consensus on what can and should be done to prevent it," said Arakaki. Because legislators are "hesitant to support mandates and bans in schools" in the long run, Arakaki thinks "lifestyle changes and strong public awareness campaigns" will be the key to reversing the obesity trend.

Hawaii is ahead of the game in that respect with its Healthy Hawaii Initiative (HHI), a public education campaign funded with tobacco settlement dollars. Launched in 1999 by the State Department of Health, HHI encourages communities, schools and businesses to help residents adopt healthy living practices.

HHI has three main targets: physical inactivity, poor nutrition and tobacco use. To tackle these scourges, Healthy Hawaii is using school-based health programs, community grants, education for health professionals, and a public communications campaign called "Start Living Healthy."

Over 40 schools and communities have been funded to implement programs and environmental policy changes such as teacher training, a walk to school day, and a joint land use agreement between the Department of Parks and Recreation and schools. HHI also is developing a data warehouse to improve surveillance and evaluation.

Despite a 48 percent funding cut to the program last year, "support for HHI remains strong," says Susan Jackson, manager of the Tobacco Settlement program. With the new research on obesity and mortality, and the federal commitment to the issue, there is a "big realization that HHI and the 'living healthy' message. . .are important," she added.

This summer, HHI will launch the second phase of the public awareness campaign. Using lessons learned, "we'll refocus our efforts from a large number of grassroots, community-based programs to three-to-five major community interventions," she said.

IN: MEASURING BMI

Indiana is among a handful of states that are exploring measuring and reporting students' Body Mass Index (BMI). Introduced in December 2003 by Brown, HB1014 calls for the Department of Education to develop polices for the measurement of student body mass indexes "as a way of tracking overweight trends and identifying students at risk," said Brown.

The Body Mass Index is a mathematical formula based on a person's height and weight that correlates with body fat. The BMI equals weight in kilograms divided by height in meters squared ($BMI=kg/m^2$). Individuals with a BMI of 25 to 29.9 are considered overweight, while individuals with a BMI of 30 or more are considered obese.

The measurement, to be recorded by school officials for "use in-house" and available to parents on request, will provide a good indication of the number of students who need attention, and, over time, will provide some "useful feedback about the success of some our prevention strategies," Brown said.

The bill also would require the Department of Education to develop health, nutrition and physical education curriculum for grades kindergarten through 12, as well as nutritional policies for food available at schools. Finally, it would limit access to vending machines in elementary schools. While the bill passed unanimously in the House, the Senate has refused to hear it, due in part, Brown says, to "vociferous lobbying by the vending machine companies and the school boards. Everyone was afraid of losing money."

Brown said he'll introduce another version next year. "I'll fight for this one to the end because, in the long run, children have to become invested in healthy living habits and be able to make good lifestyle choices. Their future depends on it." ✦*ACS*

PUBLIC HEALTH *NEWS*

States Using Evidence-Based Methods to Prevent Child Abuse

Infant found strangled. Young father found guilty in the beating death of his toddler. Innocence lost. Child abuse off the charts.

News headlines from across the nation draw attention to the plight of abused and neglected children. While the media focus on the extreme cases, hundreds of thousands of children – 860,000 in 2002 alone – were victims of some form of abuse, chiefly, neglect. About 1,400 children, most of them younger than four, died at the hands of their parents or caretakers. For many children, the first day of life is the most dangerous, as unwanted infants may be abandoned or killed. The second "peak" is at eight weeks, when daily intense crying is at its highest for most normal infants.

The long-term consequences of child abuse are enormous. Abused and neglected children are at higher risk for poor health outcomes, mental health disorders, language deficits, reduced cognitive functioning, poor school performance, substance abuse in later life, criminality, teen pregnancy and of becoming abusers themselves to future generations. The financial costs are in the tens of billions of dollars. They include child welfare services (child protection, foster care and adoption), substance abuse and mental health treatment, law enforcement and medical treatment for injuries. Society also pays for costs associated with homelessness, welfare dependency and unemployment.

It's no surprise that states and localities are struggling to "fix" the child welfare system, increase penalties for perpetrators of abuse and move children more quickly out of foster care and into permanent homes. However, most experts agree that stopping child abuse before it occurs would save lives and keep children and families out of the child welfare system. The question is: how do we achieve this?

PREVENTING ABUSE: WHAT WORKS?

There are hundreds of child abuse prevention programs around the country, with the most prevalent being group-based parent education, home visitation and family resource centers. With few funds to spare, states and localities want to invest their dollars in programs that have a sound scientific base.

Research has shown that effective programs intervene with children and families very early on – prenatally or at birth; are long-term and intensive; and offer parents help with finances, health care and mental health issues, according to Dr. Deborah Daro, an expert in child abuse treatment and prevention at the Chapin Hall Center for Children at the University of Chicago. Such programs offer direct services for children and are linked to other services that support families. Effective programs also limit the caseloads for child abuse prevention program staff to no more than 15 families per worker, hire staff with strong relationship-building skills and provide ongoing training and supervision.

Programs with these elements reduce the occurrence and intensity of child abuse, improve interactions between parent and child, enhance child development and link families to much needed health-care services, Daro said.

She cautioned, however, that not all programs will work all the time for all families. One-third of families offered voluntary services refuse to participate. And even a well-designed program can make little progress with families if the health-care system is inadequate and there are few economic, educational or other resources.

Evidence continues to mount that one of the more promising strategies to prevent child abuse are home visitation programs, especially those that use nurses. The Centers for Disease Control and Prevention (CDC) Task Force on Community Preventive Services recently reviewed published studies and found that such programs reduced child abuse or neglect by about 40 percent. When delivered by professionals – nurses or mental health workers – the programs "yielded more beneficial effects than did those delivered by paraprofessionals," such as volunteers.

The report concluded, "On the basis of strong evidence of effectiveness, the task force recommends early childhood home visitation for prevention of child abuse and neglect in families at risk for maltreatment, including disadvantaged populations and families with low-birth weight infants."

One of the most effective programs reviewed by the CDC was established by Dr. David Olds at the University of Colorado. Olds' project used public health nurses to provide at-home, intensive, long-term services to low-income, at-risk pregnant women bearing their first child. In a 15-year follow-up, researchers found that participants in the Olds project experienced 79 percent fewer child abuse reports, 31 percent fewer births and 69 percent fewer maternal arrests, compared to their counterparts in a control group who did not receive project services. Their 15 year-old children experienced 56 percent fewer arrests and 56 percent fewer days of alcohol consumption, compared to controls.

Olds' project was one of the first scientifically controlled studies of this type of child abuse prevention. Based on these findings, the Center for the Study and Prevention of Violence at the University of Colorado at Boulder designated the Olds strategy of nurse-family partnerships as a model program for violence prevention. Currently, some 14,000 children are engaged in nurse-family partnership projects in 22 states.

One of those states is Wyoming, which in 2000 allocated $2 million to create the Public Health Nursing Infant Home Visitation program. Based on the nurse-family partnership model, the program targets low-income, pregnant women and families with infants, incarcerated women, women with histories of substance abuse or mental illness, and

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PUBLIC HEALTH *NEWS*

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HEALTHTALK

LUTZKER: PREVENTING CHILD MALTREATMENT

A Ph.D. psychologist, John R. Lutzker is one of the nation's premier experts in preventing child maltreatment. Currently, he is in charge of developing and evaluating violence prevention programs for the Centers for Disease Control and Prevention (CDC). Lutzker has published over 100 professional articles and chapters, and is the author of five books, including Reducing Child Maltreatment: A Guidebook for Parent Services. He is a recent recipient of the James M. Gaudin Outstanding Research Award from the Georgia Professional Society on the Abuse of Children.

Q: What is the CDC doing to help states implement effective child maltreatment prevention programs?

A: We are involved in many activities that will help states protect children. For example, we are currently developing uniform definitions and data elements for child maltreatment surveillance. Without uniform definitions, different terms are used to describe acts of maltreatment, and these inconsistencies contribute to confusion and a lack of consensus about the magnitude of the problem.

We also have funded 13 states to establish a National Violence Death Reporting System, which will enable them to share and link state-level data about violence, including homicide, suicide, undetermined and unintentional deaths. The reporting system will enable us to gain much more accurate and in-depth information about victims of child maltreatment and abuse-related deaths.

Separately, the health departments of California, Michigan, Minnesota, Missouri and Rhode Island are comparing alternative approaches to surveillance for fatal and nonfatal childhood maltreatment, and testing methods to survey violence at all ages.

And, we're involved in something called ICARUS, a periodic in-depth injury survey. In the next one, we'll ask the public about their willingness to pay to prevent a case of childhood maltreatment. When we have those data, we'll be able to conduct much more sophisticated cost-benefit analyses on child maltreatment prevention programs. That should help the states a great deal in finding out which programs provide the most benefit for the funding dollar.

Q: You have referred to the SafeCare project in Oklahoma as an "ecobehavioral" model. Just what do you mean by that?

A: The ecobehavioral model basically stems from the belief that families are social ecologies, they are not simply individuals in vacuums. That means, if we are going to be effective in dealing with child maltreatment, we need to deal with the entire social ecology such as the parent/child relationship, advocacy for the child, community resources and so forth.

Other models rely exclusively on assessments such as rating scales or self-reports. In the ecobehavioral model, families are observed and taught right in the home and other settings. The ecobehavioral model is designed to try to teach families skills that they have not been shown before, so that they can use those skills with new challenges in new settings. So we might teach the family in the home, or we might teach them on a car ride or in a grocery store, with the hope that they can then generalize those skills to other situations. We try to teach skills that over time become durable.

The ecobehavioral model does raise some tricky issues. There's a delicate balance between intrusiveness and help. We want to assess the families as often as possible, but we have to be careful not to become too intrusive – parents might drop out.

Q: How did the ecobehavioral model begin? And is it catching on?

A: The first ecobehavioral project began in 1979. I wrote a grant when I was with the University of Southern Illinois, starting something called Project 12-Ways. Project 12-Ways has been ongoing since July 12, 1979, served over 1,500 families, brought in over $12 million dollars, and trained hundreds of developing professionals. The referrals to Project 12-Ways are rather homogeneous and are exclusively through the Illinois Department of Human Services. By homogeneous, I mean that the demography of southern Illinois is largely white poor families in rural circumstances. We have data over the years to suggest that Project 12 –Ways is more effective than other services in the same region offered to families.

That led to a grant from the California Wellness Foundation to systematically replicate Project 12-Ways in California. In doing so, we labeled the program Project SafeCare. It was different from Project 12-Ways in a number of ways. First of all, we conducted it in the urban San Fernando valley of Los Angeles, and our population was far more diverse in California, with the primary recipients of the services being Latinos.

We labeled the services in Project SafeCare "bonding," which is a systematic form of parent training, parent/child behavior management training for the parent, healthcare skills for the parent for their children, and teaching home safety and home cleanliness. In neglect families, who are the majority of families seen in child maltreatment referrals, often the very poor health and safety conditions of the home are the reason for the referrals. So the goal there is to teach families the skills they need to make the environment much safer and healthier for their children.

After three years, the SafeCare families survived at a nearly 90 percent level, meaning there were no further reports of child maltreatment, whereas only 56 percent of the families who received traditional treatment only had no further incidents. Statistically, that is a highly significant rate.

Q: What recommendations do you have for state officials who are trying to prevent child neglect and abuse?

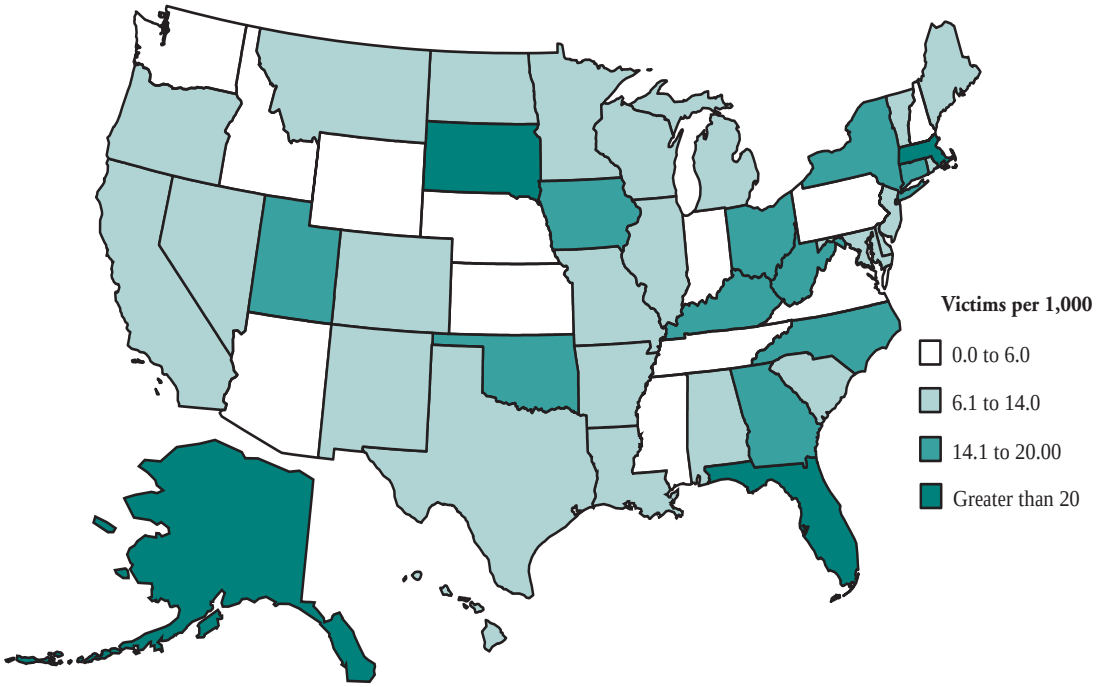
A: There are three key recommendations. First, if they are involved in evaluating a program, they should affiliate with very solid research teams. These should be teams with considerable expertise in evaluation and a record of producing publishable outcomes.

Another recommendation would be that states adopt programs that have been shown scientifically to be effective. They should evaluate and adopt only evidence-based programs – that can't be stressed enough. Many programs look good cosmetically, but if you look closely at their evaluations, those turn out to be *self*-evaluations or testimonials. Such programs should be avoided, especially if the states plan to implement them on a large scale.

Finally, I would suggest that once states choose a program, that they start small. Unless it has been proven that the program can be disseminated widely, states should test one or two regions or something very minimal, get some very good data, and make sure that the services that are delivered are the ones that were prescribed. Then, if the outcome data look good to "scale up," start expanding gradually. If you have outcomes data that show the program is cost-effective, then you've got a really robust argument for disseminating or replicating programs. *NWM*

Child Maltreatment

Rate of Child Victims by State, 2002



FAST FACTS:

In 2002, an estimated 896,000 children nationwide (12.3 per 1,000) were found to be victims of maltreatment.

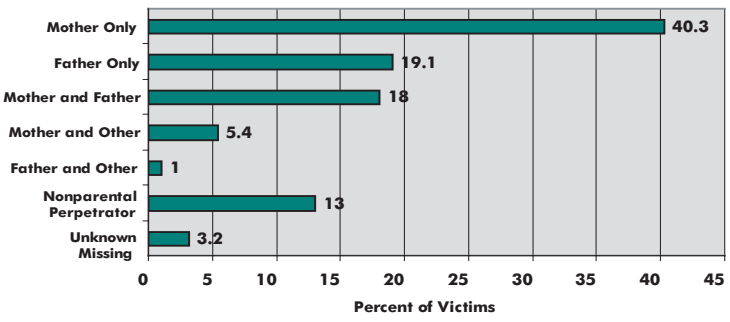
· 60% of these victims experienced neglect (including medical neglect)

·18.6 % were physically abused

· 9.9 % were sexually abused

· 6.5 % were emotionally or psychologically mistreated

Perpetrator Status, 2002



Source: *Child Maltreatment 2002*, U.S Department of Health and Human Services, Administration for Children and Families.

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victims of domestic violence. Public health nurses provide "welcome home" visits, information on infant care, service referrals and a thorough assessment of the infant's circumstances. The families receive services up until the infant's 24th month.

Wyoming is not alone in its efforts to meld effective, research-based programs with strategies to prevent child abuse. In 2001, the Oklahoma Legislature passed House Bill 1143, which sets up a pilot project to identify children at high risk of abuse and to test methods of helping those children.

"When I became a legislator, I decided to request funds for a pilot project to develop a model that would work for children and families at highest risk for child abuse," explained bill sponsor Rep. Ron Peters. "I felt that if you're going to spend government money, it has to be spent on programs that work."

The legislation requires the partners to develop services for high-risk children, coordinate state and local services for these children and their families, and include both urban and rural concerns. A board, comprising representatives from the Legislature, the Governor's office, departments in the state administration, the Oklahoma Indian Affairs Commission and the CASA Association, is to evaluate the project and report back to the Legislature by May 2005.

The provider agency selected to conduct the pilot approached the CDC to identify effective prevention programs. The agency chose Project SafeCare, a home visiting program -- orginally developed in Illinois and California -- that has proven effective in reducing subsequent reports of suspected maltreatment and in preventing neglect.

Project SafeCare is different from standard child abuse prevention programs in that it provides at-risk families with comprehensive, intensive services. Most of the families in the pilot project struggle with drug and/or alcohol abuse, mental or physical disabilities, and intimate partner violence. Project SafeCare not only provides education about basic parenting, child development and safety, but it provides services for underlying issues as well, such as counseling for mental illness and substance abuse. Services that might otherwise be fragmented and difficult to obtain thus become coordinated.

The pilot project will be tested through a randomized trial. Families will either receive Project SafeCare services or a mix of standard services, such as substance abuse counseling, mental health and parenting education.

In addition to evaluating the House Bill 1143 project, the CDC and its Oklahoma partners will conduct a four-year evaluation of Project SafeCare in a larger-scale, statewide randomized trial. Three of the state's six regions will receive Project SafeCare services and the other three will receive enhanced "services as usual" in an effort to determine which route is most effective at preventing maltreatment.

WORKING WITH CHILD CARE

Another new approach to preventing child abuse is to use early care and education settings. Through a grant from the Doris Duke Foundation, the Center for the Study of Social Policy (CSSP) recently identified 21 "exemplary" early child-care programs that work with families to reduce child abuse. These programs help parents develop parenting skills, understand child development, and access community and social supports. They may also provide concrete financial and other assistance in times of need.

The rationale is that millions of children and families enroll in child-care programs, so using them to prevent maltreatment could help large numbers of children. Also, families tend to develop long-term relationships with their child-care providers, and they often share information about their family life that they would not ordinarily share with government intervention services. Child-care providers see families and children up close and can act as an early warning system for families in trouble.

Research from the University of Wisconsin appears to support the CSSP premise. Researchers there found that low-income families who participated in an intensive early childhood intervention program run by Chicago public schools had a 52 percent lower rate of maltreatment than did those who did not. Children enrolled in the program for more than four years experienced an even lower rate of maltreatment. The benefits were greatest when the children were between 10 and 17 years old.

MIAMI SAFE START

In Florida, the 11th Circuit Juvenile Court of Miami-Dade County, the state Legislature and prevention/early intervention services have joined to help court-involved families. Funded by the state Legislature in 2000, the Miami Safe Start project provides maltreated children under three with assessments and referrals to early intervention services. Mothers and children who become involved in the justice system receive services that focus on attachment and other development issues. The project videotapes mother and child interactions and uses standard assessment tools to refer families to needed services to prevent further maltreatment.

The pilot project subsequently collaborated with the local Early Head Start agency and the University of Miami's Linda Ray Intervention Center to become the nation's first juvenile court-sponsored early head start program. Funded by the Office of Juvenile Justice and Delinquency Prevention at the U.S. Department of Justice, the now-expanded program provides children and their caretakers with the services offered in the pilot.

Florida State University is evaluating the project. Baseline data collected so far documents the factors that put families at risk for maltreatment: birth complications, language delays, mental disorders, unemployment, drug/alcohol abuse and prior jail experience.

Setting out to prevent child maltreatment can be a daunting prospect, given all the factors that come into play. But working with partners in innovative ways, states are finding that there is much they can do to protect the youngest Americans. *NWM*

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HIGHLIGHTS

MEDICAID

Family Planning = Savings

Looking to save Medicaid dollars? Consider expanding coverage of family planning services. A new report commissioned by the Centers for Medicare & Medicaid Services examined 6 of the 18 states that have waivers to expand Medicaid coverage of family planning services beyond federal requirements. Researchers at the Alan Guttmacher Institute found that Alabama, Arkansas, California, New Mexico, Oregon and South Carolina not only saved substantial sums of money, but expanded services to more people. South Carolina saved $56 million over three years starting in 1994, and Oregon saved nearly $20 million in a single year (the savings were divided between the state and federal governments). The study also found evidence in two states that unintended pregnancies were reduced. Federal law requires state Medicaid programs to cover pregnancy-related care, including family planning services, for 60 days postpartum for low-income women. States took different approaches with their waivers: some expanded the period under which postpartum family planning services are provided, others extended coverage to women who left Medicaid for any reason, while still others granted family planning coverage on the basis of income alone. For more, go to www.guttmacher.org/pubs/journals

PUBLIC HEALTH

Fun in the Sun

As summer nears and kids spend longer days having fun in the sun, the dangers of exposure to ultraviolet (UV) rays rise. In 2000, the Environmental Protection Agency developed a program to help raise sun safety awareness. The Sunwise School Program provides educational kits for children in kindergarten through 8th grades. The kits vary according to the age of the intended child; they may contain UV-sensitive beads, stickers and Frisbees; comic books; posters; UV meters; and charts and graphs of UV levels. The most potentially dangerous health effect of UV rays is skin cancer, including basal cell carcinoma, squamous cell carcinoma and – the most deadly of all – melanoma. More than 1 million cases of skin cancer are diagnosed in the U.S. each year and an estimated 10,250 people will die from it this year. Studies show that most skin cancers appear after age 50, but the damaging effects of the sun begin in in childhood.

Prevention is the best defense against skin cancer, so people are advised to limit midday outdoor activity, wear UV- protective sunglasses, use sunscreens with an SPF of 15 or greater and apply every 30 minutes, and wear protective clothing. More than 9,500 schools in all 50 states and the District of Columbia and Puerto Rico have started using the award-winning Sunwise School Program kits. They're available free to educators by calling the National Technical Information Service at (703) 605-6000.

BEHAVIORAL HEALTH

Stopping Meth Cold

In an effort to stem the manufacture of methamphetamine, many states are passing legislation limiting access to popular cold remedies. The pills contain pseudoephedrine, a key ingredient in one recipe for manufacturing methamphetamine in home labs. In Ohio, Gov. Brad Henry signed a law April 7 that allows customers to buy cold remedies such as Sudafed and Claritin-D, but only from pharmacies and only if they present photo identification and sign up for the medicine. Iowa recently passed legislation that prohibits the sale of more than two boxes of medicine containing pseudoephedrine at one time; requires that cold pills be placed behind the store counter, and mandates the posting of warning signs to customers that they will face criminal charges if they break the purchasing limit. The Drug Enforcement Administration says that small "Mom and Pop" meth labs are now found in every state in the East. The DEA estimates that 8,000 meth labs were seized last year, and 3,300 children were found in the homes that contained the labs. The cooking process releases poisonous chemicals that can spread throughout the house.

MEDICAL MALPRACTICE

Preparing for the Worst

If the medical malpractice crisis in Ohio gets much more acute, the state will set up its own underwriting association for physicians. Legislation sponsored by Rep. Larry Flowers authorizes the state insurance director to place $12 million into a new Medical Liability Underwriting Association if physicians become unable to find malpractice insurance within the state. When he signed the measure April 12, Gov. Bob Taft asked the General Assembly to also require insurers to provide 60 days' notice of cancellations or rate increases; allow doctors to insure themselves; create and fund a patient compensation fund; and establish a process to screen malpractice claims for legitimacy. In 2003, the state enacted broad tort reforms that would limit non-economic damages in malpractice cases to, generally, $350,000; restrict attorneys' fees; and impose a four-year deadline on the filing of malpractice suits. But those laws are tied up in litigation. In 2003, malpractice premiums in Ohio rose anywhere from 17 to 87 percent among the five insurers in the state that provide 70 percent of the state's malpractice coverage, according to the *Akron Beacon Journal*.

FOR YOUR *INFORMATION*

South Carolina: Preaching The Gospel on Dental Care

"People will always find a way to get to church, [but] not always to get to the doctor or dentist."

That observation, by Jeannine Smalls, an ordained minister with the African Methodist Episcopal Church (AME) and a faith-based consultant to the South Carolina Department of Health and Environmental Control (DHEC), is one of the guiding principles behind a ground-breaking oral health-care initiative in South Carolina.

Funded with a $960,000 grant from the Robert Wood Johnson Foundation and active in six South Carolina counties so far, the "More Smiling Faces in Beautiful Places" initiative seeks to improve access to oral health services for young children (particularly those aged six and under) and those with special needs served by Medicaid.

According to a 2002 survey by the DHEC, one-third of all kindergarten children in South Carolina suffer from dental decay (otherwise known as dental caries).

"Unfortunately, most children experience their first dental visit after age three, even though we now know that dental decay can begin when teeth first come in," said State Dental Coordinator Raymond Lala, DDS.

Nationwide, studies show that decay affects almost 20 percent of children between the ages of two and four, 50 percent by middle childhood and more than 80 percent by late adolescence. Decay is the most common chronic childhood disease among minority and low-income populations, who represent the sectors with the highest risk.

VISIT ONE BY AGE ONE

Managed by the non-profit Center for Health Care Strategies, More Smiling Faces takes its name from the slogan on the state's license plates: Smiling Faces in Beautiful Places. Among other things, the program seeks to educate families that children need a dental check by an appropriately trained medical or dental provider by their first birthday.

More Smiling Faces provides training in pediatric dental care for the dental team, teaches medical professionals to incorporate oral health education and prevention into their practices, and trains lay persons to act as "patient navigators." The navigators help parents secure dental care for their children and try to ensure that appointments are kept.

"The patient navigators have been invaluable in providing oral health information and assistance to the parents and caregivers of young children," said Christine Veschusio, DHEC's school dental coordinator and director of the More Smiling Faces project. "This will save the dental provider lost revenue and encourage them to participate in the Medicaid program." Dentists credit the navigators with decreasing the number of missed appointments, she added.

In another unique aspect of More Smiling Faces, the DHEC and the 7th Episcopal District of the AME Church are spreading the word about the importance of dental care.

Acting on a proclamation letter from their Bishop, the 609 AME churches in the 7th Episcopal District declared Feb. 8 to be Oral Health Sunday. Each church received a toolkit with background information on More Smiling Faces, oral health tips for families, suggestions for activities and American Dental Association game sheets.

Oral health education was incorporated into each church's worship service, and three of the participating churches held oral health fairs. More than 100 children were seen that day as dentists and hygienists voluntarily screened the children for decay.

Event organizers estimate that they educated more than 100,000 community members and parishioners about the importance of oral health. After realizing the effectiveness of the event, several other local groups are eager to get involved.

"The AME effort was significant in that it. . .set an example that other faith communities could emulate," said Veschusio. "By emphasizing health promotion and disease prevention strategies through the medical and dental providers, as well as the educational, faith and community groups, there will be a decrease in the caries burden for very young children and children with special needs."

✦ This article was written by Amanda Davis, intern with the Forum for State Health Policy Leadership.

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